MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
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10:09 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
Pass-through payments in the hospital outpatient department PPS
Chantal Worzala, Dan Zabinski

DR. WORZALA: Good afternoon. Dan and I will be discussing how Medicare pays for technology in the outpatient PPS. To refresh your memory, the Commission made recommendations on this topic in the June 2001 report and submitted a comment letter on the August 24th proposed rule. Since then a final rule has been issued.

The first part of our discussion will be a brief primer on the pass-through mechanism used to pay for certain technologies in the outpatient PPS. Then we'll turn to the treatment of the pro rata reduction in the 2002 pass-through payments in the November 2 final rule. And finally, Dan will present for you some alternative ways to pay for technology in 2003 and beyond.

Congress was concerned that the 1996 data used to set payment rates did not include the costs of newer technologies. Therefore, the BBRA mandated that supplemental payments be made when certain drugs, biologicals, and medical devices are used. That additional payment, called a pass-through payment is meant to cover the incremental costs of the item plus, for an example, when a pacemaker is implanted the hospital receives the standard payment set for that service plus an additional amount calculated from the hospital's reported cost for the pacemaker itself in the event that the costs of the pacemaker are higher than the device costs that were already included in the standard payment.

Hospitals receive pass-through payments for each eligible item for two to three years, and after that the costs of these items are incorporated into the relatively weights.

The provision is meant to be budget neutral with spending on pass-throughs limited to 2.5 percent of total payments. However, through administrative action, and at the request of Congress, budget neutrality was not maintained in 2000 or 2001. So there were additional funds flowing for these items.

That brings us to 2002. In its November 2 rule, CMS estimates that next year pass-through payments would account for 13 percent of total payments in the absence of the 2.5 percent cap. CMS also estimates that maintaining the cap on spending would require an approximately 81 percent reduction in each pass-through payment. The law does require them to make those pro rate reductions if they estimate that the cap would be exceeded.

Both price and quantity factor into the estimate of pass-through payments. Administrative and legislative actions did increase the number of items eligible for pass-through payments. In addition, the payment mechanism set in place provides incentives for hospitals and manufacturers to increase their prices, thereby paying too much for certain items in the absence of the pro rata reduction. So that's how we got to 13 percent of total payments for pass-throughs.

To avoid such large reductions in the pass-through payments,

CMS has decided to fold 75 percent of device pass-through costs into the relative weights for the related service. Your briefing material describes CMS' methodology for doing this, so I'm not going to go into details here, fortunate for all of us.

But taking our example of pacemaker insertion, it does mean that the relative weight and therefore the base payment will increase for that service. This will leave a smaller share of the device cost to be covered by the pass-through payment. That means that in toto, fewer technology costs will be flowing thorugh the pass-through mechanism and that will result in a smaller pro rata reduction. However CMS does estimate that there will still be some measure of pro rata reduction.

Under this action, CMS will maintain the 2.5 percent cap and the budget neutrality aspect of the pass-through payments. In addition, because any recalibration of the relative weights must be done in a budget neutral manner, the fold-in will also shift payments among services.

In an additional step and to further limit the reductions in the pass-through payments, CMS recommended that Congress pass legislation allowing the funds allocated for outlier payments to be combined with the pass-through allocation only for the year 2002. This would increase the funds available for the pass-through payments by 2 percent of total payments.

It's important to remember, however, that both the pass-throughs and the outlier allocations are budget neutral, meaning that conversion factor is decreased to fund them.

The action taken by CMS will increase payments for services that use medical devices eligible for pass-through payments. We have estimated that total payments for these services, that is the standard payment plus the pass-through payments, will be $800 million to $1 billion higher than they would have been if the full pro rata reduction had been made.

However, because the recalibration of relative weights is done in a budget neutral manner, as required by law, the fold-in will decrease payments for all other services. We have estimated a reduction in the range of 4 to 6 percent.

The November 2 rule did not include the actual APC groups or the relative weights. CMS has stated that they will be published in an additional rule next month. Operational systems may not, therefore, be in place to make payments under the 2002 regs come January 1. And some sort of interim payment method may be required.

So hopefully, this part of the presentation has helped you understand how Medicare will pay for outpatient technologies in 2002. Dan will now discuss some alternative ways to pay for technology in 2003 and beyond.

DR. ZABINSKI: Now the policy actions that Chantal just discussed failed to address some important problems in paying for technologies in the outpatient PPS. We have identified three policy alternatives that would address those problems.

One option is for CMS to continue the pass-through system

but to make some modifications. A second option is to pay for all technologies on a fee schedule outside of the outpatient PPS. A third option is to phase out the pass-through payments and reimburse technologies only through the base payment rates in the outpatient PPS. On the next few slides, I will discuss the advantages and disadvantages of each of these options.

The first option of continuing the pass-through system is the advantages that the system is already established and that it facilitates payment for new technologies because there is no need to wait for the data necessary to establish payment rates or service categories. But the pass-through system imposes an arbitrary cap on spending of new technology and it places an administrative burden on hospitals and CMS to process the special information necessary for pass-through payments.

Also, it distorts relative payments in favor of services that use pass-through items. This is because the base payment rates in all APCs are reduced by the same percentage to make pass-through payments budget neutral, but the pass-through payments themselves are not reduced by that percentage. This problem is exacerbated by incentives for hospitals to increase the reported cost of pass-through items to increase pass-through payments.

If CMS chooses the option of continuing the pass-through system, the agency and the Congress should address three additional issues. First of all, the pass-through system should exclude items whose costs are reflected in the data used to calculate the base payment rates. Pass through payments for these items are not necessary because the base rates take their costs into account. But this action would require legislation because a BIPA provision makes such items eligible for pass-through.

Second, CMS and the Congress should replace the facility-specific pass-through payment for devices with some sort of national rate system. The facility-specific payments of charges adjusted to cost give hospitals incentive to increase reported cost by raising its charges, and thus increasing pass-through payments.

Finally, pass-through payments should reflect only the incremental costs of the pass-through items. Currently, the incremental costs are determined as the reported cost of the pass-through item minus the cost of the item being replaced in the applicable APC group. But the costs of the item being replaced may be under-represented in the APC group, so the amount of the incremental cost being calculated may be too high. Consequently, pass-through payments may be higher than they should be, which increases the likelihood of exceeding the 2.5 percent cap.

The second option for paying for technologies is to remove all technologies from the outpatient PPS and pay for them using a fee schedule. This would eliminate the need for pass-through payments. The advantage of doing this is that it would no longer

distort the relative payments in favor of services that use pass-through items and it avoids cost-based payments which give providers and manufacturers incentive to raise reported costs to increase pass-through payments. The disadvantage is that it would require unbundling, which can lead to higher expenditures on technologies through increased use and upcoding.

Finally, the third option for paying for technologies is to phase out the pass-through system and pay for all technologies under the base payment rates. This would no longer distort relative payments in favor of services that use pass-through items. Also, it would remove the bias in favor of using new technologies because of pass-through payments exceeding the acquisition costs of the items. Finally, it would reduce the administrative burden faced by hospitals and CMS.

The disadvantage of doing this is that we may underpay for high cost new technologies, causing hospitals to choose not to use such technologies.

Just in closing, I'd like to say that our intention for our analysis of these options is to lead to a chapter in the March 2002 report. We ask commissioners to provide comments on these options or other options they may have considered. We would especially appreciate their thoughts and directions we should take that might lead to recommendations.

MR. MULLER: I have a question and a comment. In the text you point out that CMS has not been able to, in a sense, deduct the cost that's contained in the APCs, and therefore, in a sense, exacerbating the amount that the 13 percent is over the 2.5 percent.

Roughly, do you have an estimate of what if they had been able to do that? If they had been able to deduct that from the pass-through payment, how much -- instead of 13 what would it be? Would you have any sense of that?

DR. ZABINSKI: Actually, the 13 percent in 2002 does make a deduction for all pass-through items. Previous to 2002 they weren't able to do that. The problem is that the amount of the pass-through items in the base rates for devices speculated that it's under-represented. But how much under-represented is hard to tell, so I wouldn't know how much exactly that would reduce the 13 percent. It would make it lower, but I have no idea by how much.

MR. MULLER: I have another question, but I think in the flow of the conversation I'd rather come back to it later.

DR. STOWERS: I'm probably really going to show my ignorance here. If we were getting rid of the pass-through and we're folding it into the APCs, then it would be taken out of all of the other APCs or from all hospitals then; correct? So would we not have the cost borne for this technology also affecting the hospitals that are not using that technology? So we would be taking that 4 to 6 percent drop, or whatever it is, out of the small community hospital or whatever? Am I making sense in that?

And those are the ones already that had the lowest Medicare

margin.

MR. DEBUSK: Ray, about 8 percent.

DR. STOWERS: So I'm really wondering if this is an appropriate way to pay for the technology in centers that are using a lot of technology is to lower the base payment of all the hospitals. I just bring that up.

DR. NEWHOUSE: Ultimately this is the new technology problem we were dealing with blood. It's the same problem and it does apply to both inpatient and outpatient. IT's just that the Congress has put an explicit adjustment on the outpatient side and not on the inpatient side.

Within this context, I don't seen an obvious answer. Every course has its own problems. So it's a question of which set of problems we'd rather have.

I think I tend to come out liking the fee schedule, but I could be talked out of that feeling. Then I think I like the modifications to the pass-through system. But it's an issue of how fast we think that the base rates will be updated for new technology. How important the legs are. Will hospitals adopt the new technology and take the one-time hit until the base rate gets updated as it was in the blood case?

The problem with the pass-through, which we're seeing, is that -- particularly for devices or technologies with a high Medicare share -- there's a tremendous incentive just to price it to the hilt on the part of the manufacturer or supplier. That then leads you in the direction of a fee schedule which is basically then a price control. But I don't see any other good option, no happy outcome.

MR. HACKBARTH: Is there a reason for thinking that the technology problem on the outpatient side is different than on the inpatient side? Congress opted to do this pass-through. Was there an analytic basis for that, as opposed to a political basis for it?

DR. WORZALA: Can I speak to that a little bit? This goes back -- I actually misspoke at the beginning of my presentation. It was the March report when we last spoke about this issue, where we addressed how technology is paid for in both the inpatient and outpatient setting.

We pointed out some differences in the two prospective payment systems that may lead us to think that separate treatments are appropriate, things like the smaller unit of payment on the outpatient side, the fact that on the outpatient side you pretty much need a code to be paid for anything, as opposed to a DRG where you can choose to use different technologies within the DRG payment without a code.

So these are some of the differences that may suggest different payment mechanisms.

Also, to refresh your memory, BIPA did include provisions requiring additional payment for new technologies under the inpatient PPS. And those systems have been further developed by HCFA.

DR. REISCHAUER: Dan, just if you could enlighten me. We have a situation where we have 13 percent now. Part of that is attributable to the fact that there's technologies that are really in the base that shouldn't be there. They're there for political reasons. What if that weren't the case? Do we know how much that would lop off?

DR. ZABINSKI: I don't know.

DR. WORZALA: I think the only thing we can say is that it would be significantly smaller. I tried to allude to this. What's accounting for the 13 percent is two things. One is the incentives in the system to overstate price, and the other is a considerable expansion --

DR. REISCHAUER: I was going to ask you about that next.

DR. WORZALA: A considerable expansion in the eligibility criteria for the pass-throughs between BBRA and August 1, 2000. Both administrative action and legislative action did explode the number of items that would flow through the pass-through mechanism, so that over 1,000 devices were eligible as of January 1, 2001.

So all of that will sunset in 2003 and be folded into the base so that moving forward we can expect that it will just be truly new technologies with a much narrower set of criteria applied by CMS for eligibility for the pass-through payment. So we can expect that it will be much smaller than 13 percent but we can't, obviously, know what the number will be.

DR. REISCHAUER: So there's a big chunk, this significant chunk of the problem is going to go away.

DR. ZABINSKI: Hopefully.

DR. REISCHAUER: If the political system doesn't respond and continue. But then there's the notion of moving to national rates. I'm thinking about how big -- you don't, as a single hospital, have a direct, but you certainly have an indirect or a collective incentive to jack up your prices as well. Is there an alternative, like taking rates out of what the VA pays or something like that?

MR. MULLER: In fact by taking it out of the APCs, whether it's four to six, you get hit because it is a pass-through. You don't get those "jacked-up rates." So by having it folded in the way the November 2nd rule does, in a sense you get penalized for having this be so big. You follow me? If you show no judgment for what you pay for these devices and they get folded into the APCs, your APCs go down. So in a sense, a hospital gets penalized --

DR. NEWHOUSE: The APC is a national rate.

MR. MULLER: I was just asking Bob a question. I would think hospitals get penalized for not being diligent purchasers.

DR. REISCHAUER: Are you telling Dan that he's right except he has the sign wrong?

MR. MULLER: The device manufacturers have an incentive to jack up. The hospitals get penalized for not being prudent in resisting that jacking up.

DR. ZABINSKI: I don't know, I see it as, I start thinking of game theory. If one guys does it and nobody else does, he wins. If they all do it, they all lose.

MR. MULLER: But the hospital doesn't get the mark up. It gets passed through to the device manufacturer, correct?

DR. NEWHOUSE: Ralph's point is, given this 75 percent, the 75 percent is averaged over all hospitals. So it's not hospital specific, whereas the pass-through is. That's really what's going on. So it doesn't -- Ralph's right then, it's not to the hospital's advantage.

MR. MULLER: Yes. It's a disadvantage.

DR. NEWHOUSE: For that 75 percent.

DR. ROWE: It's actually 62 percent because you take 75 percent and you multiply that times 0.83, so you get 62 percent of so.

MR. MULLER: Right. The point is still, there's a disadvantage to a hospital by not -- of course, they have no choice in what they're paying if they're paying the average price which is set by wholesale prices set by somebody else.

MR. DEBUSK: Chantal, after 2003 and this all rolls back into the APC, then from that point on is new technology going to be new for 12 months and then rolls back?

DR. ZABINSKI: Two to three-year timeframe by law. BBRA specified that, each category or drug has to be eligible for two to three years.

MR. DEBUSK: Let me make a statement here about, you look at the effect of the new technology and the way the system works now, somehow we've got to unbundle this technology because we can't take new technologies, new cost, new procedures and every so often we take and look at this, it becomes budget neutral. Who pays for it? Then the people it's really going to hurt if we don't unbundle it is going to continue to be the small hospital or the small urban hospital or mid-sized rural hospital.

This is one of the things that's breaking their back now is because as higher technologies, new technologies are paid for, then their APC codes, which they do a lot of the routine APC codes, this just takes money right out of their pocket. At the same time, if you think about it, you're taking into consideration only 4 percent of the APC codes actually have a device tied to it.

DR. WORZALA: I will try to give you Julian Pettengill's answer to that question which I've asked him repeatedly, and he'll back me up if I get it wrong. The notion is that under normal circumstances, if you're not taking this big 13 percent chunk and moving it over all at once -- it's not exactly 13 percent. But anyway, when you recalibrate the relative weights that is done in a budget neutral manner so that there is decrease in the relative weights for lower level services and increase in the lower higher services.

But what you are then doing is putting an update in as well, and the update to the conversion factor should be including the

medical inflation of new technologies. So that that raises payments for all services.

DR. NEWHOUSE: But how is that computed? We haven't exactly succeeded in doing a wonderfully precise job on the inpatient side.

MR. DEBUSK: There's some difference in this median and mean. Sometime, Dan, I'd like for you to explain that to me, how they're calculated. But that's another subject.

DR. STOWERS: I may be being redundant here, but when we say that the problem is going to go away, are we not saying that it's going to get folded in and lower the overall base rate, because that's going to fold in in a couple of years or whatever. Then again we're, not being redundant with what Pete is saying, is we just keep lowering the base down so that those that are not using the technology are going to go on. So if we adopt this over the long haul then it keeps getting worse and worse with time.

I think the problem is that we've got to face with Congress is that the 2.5 percent is not covering what happened here. Trying to do this under some kind of a 2.5 percent base. So we can't raise the 2.5 percent base so let's start penalizing the small hospitals and all of that, and just keep taking it out of their base, and we're going to expect the small hospitals to pay for the technology in the big centers, which is what this really sounds like.

Maybe I'm misunderstanding it, but in the long run this is where that would head I think. So we've got to face the fact that this 2.5 percent is not covering what happened here. I think that ought to be very explicit in our report.

Number two, I think we ought to -- if we've got the time here, and it looks like we do, I think we ought to run out the impact numbers on this over a period of time for the different size hospitals to make it very explicit what's happening to who in this particular process. Because I think Congress needs to be aware of what's happening here.

MR. DEBUSK: Let me ask another question. Here they've taken this hit. Do they ever get this money back to catch up with this marketbasket? The marketbasket last year, they got an increase, and now here it's gone again. Do they ever get it back and going forward?

DR. NEWHOUSE: This is the scientific and technical advance number. In principle, if that is adequate, that's what's supposed to -- how this is supposed to be accounted for. One other note on Ray, in telling the Congress 2.5 percent doesn't do it, it's partly because we've set it up as a pass-through that it doesn't do it. That is, there's incentives to use more of it, price it higher, and so forth.

DR. STOWERS: The question is who pays for it.

DR. LOOP: If the 2.5 percent is still there, it still doesn't do it and I think that has to be reevaluated. Maybe it's out of the purview of this chapter, but with all the advances in drugs, devices, biologicals, that figure is not right.

The other thing, now maybe I just don't understand this chapter but you've got one payment methodology for technology in the outpatient and one for the inpatient. They're not really compatible. And for progress it seems that you want to move a lot of the high cost inpatient to the outpatient setting. Now doesn't the incompatibility retard that progressive move of more procedures to a lower cost outpatient setting?

DR. NEWHOUSE: It's the other way around.

MR. HACKBARTH: Technology is more favorable on the outpatient side.

MR. MULLER: Favorable to whom?

DR. ROWE: To the hospital.

DR. NEWHOUSE: Shifting it out.

MR. MULLER: There is a technical discussion that's going on here, but an appropriate one. The pass-through goes to the manufacturer. There's this redistributional effect that hits all hospitals. It doesn't just hit the rurals.

So this is not a redistribution, Ray, I would say from the small to the big hospitals. I obviously don't want to rise to the bait, though I obviously have. So it's not a redistribution from the small to the big. It's a redistribution by taking a category of device and saying they'll be paid for it 95 percent of cost, and the cost, for the reasons you've all suggested, can go up more than other costs that are more constrained.

So it's that kind of redistribution outside of the outpatient setting, whether it's in a small or large hospital to device manufacturers, perhaps -- probably reflecting some outside reality, which is why they got it through. I think Joe's preference for a fee schedule at least puts some constraints on that in that sense. So I think it has a lot of virtue in going in that direction.

But as long as you have, in this case like the fold-in, on the one hand there's a lot of sympathy around this table for having the appropriate technology enhancing the lives of beneficiaries and getting it out there. On the other hand, given budget neutrality if getting those technologies to beneficiaries just gets folded back into the base rates there's a major redistribution going on of service that may not necessarily positively affect beneficiaries in the long term.

So that's, I think, the kind of question that's going on here is that, if you have too much of the -- whatever the right number is. If the 2.5 is blown by too big a number, I think we would all say 13 versus 2.5 is too big an overage of a ratio. By then folding it back in it takes away a lot of the power of supporting the introduction of new technology in the first place.

So I think going back, if I could just briefly, on the discussion we had on blood. One of the things we have to be thinking about, as you have, is how does this kind of science, technology, how does it get introduced appropriately and quickly, to go back to Floyd's point, into the payment system in a way that both advantages beneficiaries but doesn't have the kind of

very distorting effect that seems to have occurred in this particular situation.

DR. ROWE: I want to go back to the principle or the rule that we discussed when we were talking about blood about not having the payments provide a distortion of the location where the service is provided. I want to make sure I understand what the rules are here.

Let's take an example of a stent that's being used for an intravascular procedure, which is increasingly common and which I think in many instances can be done in the outpatient setting as well as the inpatient setting, for an aneurysm or really a major thing. Let's say the stent cost $10,000, which I think is not an unusual number for a stent, right, Floyd?

So what happens is if you have that -- if you're a Medicare beneficiary and the hospital does this and admits you, and you get exactly the same radiology suite and interventional cardiologist or vascular surgeon, whoever is doing it. The hospital gets paid for that DRG, if you will. Then if you count that as an outpatient rather than an inpatient, basically the same exact things are going to happen to the patient. They're going to be there for the same amount of time, et cetera.

Then the hospital gets paid 62 percent of $10,000 plus -- is that right?

DR. NEWHOUSE: Marked down by this 2.5 percent over 13.

DR. ROWE: I'm just trying to understand what would happen, and would there be a distortion, and is that something that we should at least bring to people's attention? Is that a bad idea?

MR. MULLER: This is a major redistribution, at 13 versus 2.5 -- and I think as Dan pointed out, it's much less than 13. It's probably more like eight or nine. But it's a redistribution from outpatient settings in large, medium, and small hospitals to device manufacturers. That's the redistribution. It's from hospitals to device manufacturers, not from small to large hospitals.

In that spirit, my other point earlier, I see no reason to put the outlier pool in here as well. Given this is already a redistribution, why you would put the outlier pool -- the outlier pool is there for some purpose, some substantive purpose. Unless we have evidence that the outlier pool is being used for -- is not being used at all for the purpose for which it was established, why you would want to throw the outlier pool into this as well, to have even --

MR. DEBUSK: It's not being used.

MR. MULLER: They're recommending that.

MR. HACKBARTH: I'm just trying to follow where you're going, Jack.

DR. NEWHOUSE: We're not recommending that.

DR. REISCHAUER: That's what CMS is doing this year.

DR. NEWHOUSE: That's what CMS is doing.

MR. HACKBARTH: So we have a system that is not neutral between inpatient and outpatient, and as currently constituted

involves a significant redistribution, if Ralph is right, from all hospitals to device manufacturers.

DR. NEWHOUSE: It's really what we think is an artificially large redistribution because of the incentive of the pass-through system. There's always going to be --

DR. ROWE: So maybe our responsibility is to point all this out to Congress rather than to --

MR. HACKBARTH: Fair enough. But I hope we can go a little bit further and say, this is what we recommend to replace it. But that's where you were headed with that?

DR. ROWE: That's where I was heading was to say, rather than -- to step back and say, guys, we think you made a mistake. We think you did the wrong thing. Or these are the consequences, maybe unintended, now that we've thought about, or something like that.

DR. ROSS: That's absolutely where I think the Commission needs to go. I would just remind you that Joe opened up the bidding with, there are no good alternatives, at least there are certainly no perfect alternatives. You may have to use some other criterion by which to make some assessments, and think back to the issue on operational feasibility, regulatory complexity. All of those things are going to play in because all of the systems that we'll talk about, and options that we'll bring you, are going to have either incentive problems, redistributional problems, something you don't like. But you're going to have to make a call.

MR. HACKBARTH: But let's just build this one step at a time. Do we have consensus on the points that Jack has made, which is we've got a problem of not having neutrality between inpatient and outpatient.

DR. NEWHOUSE: You've got that across the whole -- we've got it for lots of reasons other than this.

DR. ROSS: But this may be minor relative to all the other on that interface.

MR. HACKBARTH: To me what it means is that you wouldn't want to be going down a path with the pass-throughs, and unless there is some real or compelling reason to do that, because this is a major breach of the neutrality.

DR. NEWHOUSE: I would have said the more important point was the incentive, what Ralph was talking about and the incentives on the pricing and the device side.

MR. HACKBARTH: I don't think it's either or. I think it's additive.

DR. NEWHOUSE: It is additive, but I think -- my guess, I haven't looked at the numbers but my guess is this is actually not a major incremental distortion of the inpatient-outpatient decision.

DR. REISCHAUER: Just a point of clarification, Chantal, if you could. Is the first 2.5 percent, in a sense, free and clear, or have they reduced the APCs already?

MR. MULLER: They did it already.

DR. REISCHAUER: They reduced them already.

DR. WORZALA: That's correct. Yes, it's budget neutral so it was already reduced.

DR. REISCHAUER: It was budget neutral. It strikes me this whole discussion is part of a much, much bigger problem, which is how fast should technology progress in the medical area, and what role should Medicare play in facilitating financing that? There is no right answer to that question. If you pay for it, they will come. It could be 40 percent, if you put the money out on the table.

We are a technologically biased society that always wants to believe that new is better, and whatever it is, improves things. But we haven't said a word about what the benefits are from this or how the benefits stack up against the cost. There's sort of a tone in some of this discussion that, sure, there's some incentives to do too much, but gosh, we're constraining this system unnecessarily, or below some optimal level. And I'm not at all sure we are, at 2.5 percent.

If we decide that that's the right pace of technological advance in outpatient, it should be maybe the same in home health, it should be maybe the same in inpatient. I'd like to see this placed in a larger context. Maybe only a few paragraphs --

MR. MULLER: Bob, I didn't hear that being said. In some ways I would say, the outpatient system is fraught with so many moving parts, such a lack of data, so much confusion. Almost every negative thing you could say, you could say about the system. So to therefore say, but in this system that's fraught with all those challenges we're going to protect one part of it and take this money off the top really exacerbates a very difficult situation.

So I would say this is not something that I think is a great thing to do in a world that is so muddled, to protect one part of it and say, we'll take some money off the top in an incredibly muddled system where there's very little data, real information, as we discussed last time. So I'm not in favor of protecting this at a time when the system is going through such major transition and the data is lagging and faulty.

MR. DEBUSK: Bob, first of all, with all this new technology --

DR. REISCHAUER: I was hoping you'd come back --

MR. DEBUSK: We're trying to save your life, make you live longer.

DR. REISCHAUER: After another year of this you won't be trying to save my life, Pete.

[Laughter.]

MR. DEBUSK: Let me better understand, like a lap-choles procedure, these numbers -- I think these numbers are right. But in the hospital, if you have a lap-choles procedure they pay some $4,500 for the procedure. If it's an outpatient, an APC, they pay $1,500. I thought the idea in trying to move stuff from in

the hospital to an outpatient was to save the government money, to save Medicare dollars, to save cost in the whole system.

Now you come along and what's driving so much innovation with devices and what have you in this outpatient setting, you know a new technology -- I don't have to go over the advancements that are being made, and a lot of it is certainly tailored toward the outpatient setting because the surgery centers across this country are just exploding. Doctors are moving more and more of their patients to an outpatient basis and supposedly it's reducing cost, et cetera.

One of my contentions is that we got to be careful about what we're doing to the integrated health care system, the big hospital, because we know we've got to have that. There's a delicate balance here that I think we're going to have to address one of these days.

DR. ROWE: Pete, can I make a clinical point though that's relevant to this and I think is important? If you just say we pay $4,500 inpatient, $1,500 outpatient; it's the same procedure, it doesn't make sense. The other clinical point is in fact that the patients who are going to get done in the inpatient are the 280-pound, 82-year-old diabetic patient with angina who needs different anesthesia, and monitoring, and care, et cetera.

Not all lap-chole patients are the same, so that the ones that are lower risk get done in a setting where there are less resources that are needed to be brought to bear to do it safely on the patient. So we just need to recognize that, that there is a natural selection of these patients to different environments, and that's part of justifying that differential in payment.

MR. DEBUSK: Probably there's more money made off of the outpatient at $1,500 than you make at $4,500 because of the complexity. But why cannot new technology and substantially improved technology, it looks to me like if we recognize this separately, put it together in such a way that after a product is approved by the Food and Drug Administration in relatively short order we address the features, the benefits, the value? Joe, maybe we go back and set a rate for this product. But anything short of that I think we're -- I just don't see how we're going to get there.

MR. HACKBARTH: We've got to move ahead. This is something for our March report so we don't need to resolve it today. I'm not sure I hear a whole lot of consensus thus far.

DR. NEWHOUSE: I heard a little consensus on a fee schedule.

MR. HACKBARTH: I'm still at a higher level. If we can get as much neutrality as possible between the two settings, that would be a good thing. We certainly don't want to use payment mechanisms that result in redistributions to device manufacturers away from providers.

DR. NEWHOUSE: But even between hospital and outpatient, you've also got the ASC and the office which are not part of this that we're talking about, which may be quite relevant.

MR. HACKBARTH: Right. Fair enough. We have the

overarching question that Bob has identified. The big policy question is, regardless of setting, how much do we want to pay for the new technology?

I don't feel like we have any agreement whatsoever about the specific policy options that were outlined. I'm just too confused myself to even have an opinion. So that's where I think we are right now. Are there any specific, very pointed questions, Dan or Chantal, that you have for us that would help you prepare for the next discussion on this?

DR. WORZALA: Would you like us to continue on the path that we've set so far of options, or would you like us to have more discussion of these bigger issues?

MR. HACKBARTH: I think that you need to drag us back to the options since ultimately that's what we have to produce. So that's a constructive role you can play.

DR. ROSS: What we'll bring you is some of the options, perhaps evaluated against some of the criteria that have been laid out in terms of clinical neutrality, and avoidance of distribution outside the system.

MR. HACKBARTH: That's great.

Okay, thank you very much.